FLU

Colorado Influenza Vaccine
Vaccine Screening and Administration Form

Please print neatly in capital letters as shown in the example:

EXAMPLE 123

Please answer all questions as completely as possible.
Please use only black ink to complete form.

The administration record is on the reverse side of this document.
You will receive a record of the vaccination to take home with you.

Please complete ALL the information below as accurately as possible. If you are completing this form for your minor child, do not use nick-names or abbreviations, except where allowed. All information is confidential.

Last Name | First Name | M.I.

Date of Birth (M M / D D / Y Y Y Y) | Age: (years) | (months) (If less than 4 years old) | Patient/Representative Daytime Phone Number

If under 18 years of age please complete: Parent First Name | Parent Last Name

Address | Apt. Number

City | County | State

Zip Code | E-mail Address

Gender Identity ☐ F ☐ M ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine ☐ Non-Binary ☐ Un-specified ☐ Decline to Provide

Ethnicity (please check one)
Hispanic/Latin/a/o/x
Y ☐ N ☐ Decline to Provide ☐

Race(s) check all that apply
☐ American Indian/Alaskan Native
☐ Asian
☐ Black, African American
☐ Native Hawaiian/Pacific Islander
☐ Other
☐ White
☐ Decline to Provide

NOT REQUIRED

If your child is between ages 6 months and 9 years of age, please answer the following: Has your child ever had a total of 2 doses of flu vaccine? Y ☐ N ☐ Don't know ☐

	Health Screening Questions	Yes	No
1.	Are you or your child sick today or have a fever?		
2.	Have you or your child ever had a serious allergic reaction (anaphylaxis) to flu vaccine or any ingredients like gelatin, antibiotics, or other ingredients?		
3.	Have you or your child ever had Guillain-Barré Syndrome within 6 weeks after getting a flu shot (a type of temporary severe muscle weakness)? (Should not get nasal spray flu vaccine.)		
4.	Are you or your female teen pregnant or planning to become pregnant in the next 2 months? (Pregnant individuals should not get nasal spray flu vaccine.)		
5.	Are you or your child receiving aspirin-or-salicylate-containing medicines? (Should not get nasal spray flu vaccine.)		
6.	Do you or your child have a weakened immune system? (Should not get nasal spray flu vaccine.)		
7.	Is your child younger than age 2 years? (Should not get nasal spray flu vaccine.)		
8.	Does your child age 2 through 4 years have asthma or a history of wheezing in the past 12 months? (Should not get nasal flu vaccine.)		
9.	Do you or your child have a medical condition like diabetes or heart disease? (Should not get nasal flu vaccine.)		
10.	Do you or your child have cochlear implant(s) or have a cerebrospinal fluid leak? (Should not get nasal flu vaccine.)		
11.	Is your child 5 years or older and has asthma? (Should not get nasal flu vaccine.)		
12.	Are your or your child around anyone that is severely immunocompromised (someone that requires a protected environment)? (Should not get nasal flu vaccine.)		
13.	Are you over 49 years of age? (Should not get nasal flu vaccine.)		
14.	Are you over age 65?		

Continued on Next Page

Last Name

First Name

Date of Birth M M / D D / Y Y Y Y

For children betweenages 6 months and 9 years:

Dose Number: 1 ☐ 2 ☐

Authorization to Administer Influenza Vaccine

I have read or had explained to me the Vaccine Information Sheet for the Influenza Vaccine that I and/or my child will receive. I understand the benefits and risks of receiving this vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Signature of Patient/Parent/Legal Guardian/Medical Power of Attorney: _____ Date: ____/____/____

Parent First Name

Parent Last Name

STOP: DO NOT WRITE BELOW THIS LINE-FOR CLINIC STAFF ONLY

VFC PIN: 7434

Provider Type: ☒ Public ☐ Private

Clinic Name: MVU-5

Provider Name

Manufacturer

☐ GSK ☐ Seqirus
☐ ID BioMed ☐ PSC
☐ PMC (Sanofi) ☐ MedImmune, Inc

Brand Name

Lot Number

Dosage

☐ 0.25 ml ☐ 0.7 ml
☐ 0.5 ml ☐ 0.2ml (0.1ml/nostril)

Site

☐ LD ☐ LT
☐ RD ☐ RT
☐ Nasal

VIS Publication Date

IIV ____/____/____

LAIV ____/____/____

Date Administered M M / D D / Y Y Y Y

Administered by:

Name _____ Title _____